2026

Sunflower Medical Group

PATIENT INFORMATION

Name:	**Date of Birth:**
Address:	
City:	**Language:**
State: **Zip:**	**Primary Phys:**
E-Mail Address:	**Employer:**
Home Phone#:	**Emergency Contact:**
Work Phone#:	**Emergency Phone#:**
Cell Phone#:	**Emergency Relationship:**
Race: **Circle One: Hispanic/Non-Hispanic**	**Sex:** **Gender Identity:** **Sexual Orientation:**

FINANCIAL RESPONSIBILITY

Name:	**Date of Birth:**
Address:	
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Policy Holder:	**Policy Holder:**
DOB:	**DOB:**

Authorization to Pay Benefits to Physicians: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself of my Provider, Sunflower Medical Group when they accept assignment.

Authorization to Release Medical Information: I hereby authorize Sunflower Medical Group to release any information necessary for my course of treatment.

For Medicare or Medicare Replacement plans: I hereby authorize my provider to bill monthly for chronic care management services. You have the right to stop services at any time.

Acknowledgement of Privacy Notice: I acknowledge that Sunflower Medical Group's Privacy Notice, effective November 10, 2013 was made available to me.

___Yes___No Our office can leave messages to return our call on
____home answering machine,____office voice mail, _____cell #

I hereby authorize the following individuals to access my medical information

Name_____**Phone Number**_____
Name_____**Phone Number**_____

_____ _____
Signature **Date**

Sunflower Medical Group

Cancellation Policy/ No Show Policy for Doctor Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

1. *Cancellation/No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to an emergency or for unexpected events for work or family. However, when you do not call to cancel an appointment, you prevent another patient from getting treatment. The situation may also arise where another patient fails to cancel and we are unable to schedule you for a visit in a timely manner.

A "no show" is defined as someone who misses an appointment without canceling it within a 24 hour working day in advance

How to cancel your appointment:

If you need to cancel your scheduled appointment, we require that you call within one working day in advance. Your early cancellation will give another person the possibility to have access to timely medical care.

To cancel an appointment, please call our office between 8:30am through 5:00pm at (913)722-4240.

2. *Scheduled Appointments*

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. Adjustments in schedules are up to the provider's discretion.

If a patient is 15 minutes past their scheduled time, we may have to reschedule your appointment.

**** You may be billed for the following****

Same Day Appointment Cancellation **$40.00**

No Show Fee **$40.00**

Print Patient Name	Signature/Parent/Guardian	Date of Birth	Date

Sunflower Medical Group

Patient Portal eMessaging Billing Authorization

Our goal is to allow established patients to communicate more easily with us through our patient portal. The eMessaging through the patient portal will make regular communication more flexible. In order to manage this way of communication we have had to implement a policy for eMessaging through the portal.

We understand that having electronic access to your provider is very helpful. However, at times the amount of time required of a provider to answer questions and discuss medical concerns becomes very time consuming.

This policy is notification that you may be billed for eMessaging.

Your signature is acknowledgement of this policy.

Print Patient Name_____

Date of Birth_____

Date_____

Patient/Guardian Signature_____

ROELAND PARK OFFICE – 5675 ROE BOULEVARD SUITE 100, ROELAND PARK, KANSAS 66205 • PHONE: (913) 432-2080 • FAX: (913) 432-5183
LENEXA EAST OFFICE – 10950 W. 86TH STREET, LENEXA, KANSAS 66214 • PHONE: (913) 722-4240 • FAX: (913) 721-0298
PRAIRIE STAR OFFICE – 9300 MEADOW VIEW DRIVE, LENEXA, KANSAS 66227 • PHONE: (913) 299-3700 • FAX: (913) 721-3316
HEARTLAND PRIMARY CARE – 2040 HUTTON RD., SUITE 102, KANSAS CITY, KANSAS 66109 • PHONE: (913) 299-3700 • FAX: (913) 721-3316

www.sunflowermed.com

Consent for Release of Health Information – PLEASE PRINT

Patient Name:_____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip : _____

I authorize and request:

Release Records From: (Please include all information)	**Send Records To:** (Please include all information)
Facility Name/Doctor:	Sunflower Medical Group – Lenexa East
	10950 W 86th St
	Lenexa, KS 66214
	Attn:
Phone:	Phone: 913-722-4240
Fax:	Fax: 913-721-0298

Information to be released:

[ ] 2 years prior from last date seen (PCP)
[ ] Colonoscopy/EGD/Pathology
[ ] Mammogram
[ ] Pap Smear
[ ] Eye Exam
[ ] Lab Reports
[ ] Immunizations
[ ] X-Rays/MRI/CT/Ultrasound
[ ] Hospital
[ ] Other: _____

Purpose of disclosure:

[ ] Change of Insurance
[ ] Continuation of Care
[ ] Establishing with new PCP
[ ] Other: _____

HIPAA Privacy Statement

I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person specified above. Drug, Alcohol & Sexually Transmitted Disease records, including HIV (AIDS virus) are specifically protected by federal regulations and by signing this authorization I am allowing the release of those records unless otherwise written. I understand that my records may contain information regarding psychiatric treatment plans and specific information that unless I specifically decline and specify in writing, will be disclosed upon signing this release. I understand that some records will be re-disclosed from another facility if included in my medical record. I also understand that I may revoke this authorization at any time by written request from myself or personal legal representative on my behalf. I understand that the revocation will not apply to information that has already been released. Medical Records requests will be at the discretion of the facility when processed.

*This release of information shall remain in effect for 1 year from the date of signature below unless revoked earlier. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request.

*I have read the above and do hereby acknowledge that I fully understand the terms and conditions of this consent.

*I understand that I am responsible for any and all fees that may apply when requesting medical records.

Date: _____ **Signature:** _____

Sunflower Medical Group Health History Form

Name:_____ Date of Birth:_____ Date:_____

Local Pharmacy:_____ Mail Order Pharmacy:_____

Have you ever had any of the following?

	YES	NO
Colon Cancer		
Breast Cancer		
Heart Disease		
Diabetes		
High Blood Pressure		
High Cholesterol		
Arthritis		
Other		

Please list all medications, dosage and how often:

Name of Medication	Dose	Frequency

Please list any allergies and reactions:

Allergies:	Reactions:

Health Maintenance:	Where was this done:	Date:
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Eye Exam		
Flu Vaccine		
Pneumonia Vaccine(s)		
Tetanus/Tdap Vaccine		
Shingles/Chicken Pox Vaccine		
Covid Vaccine(s)		

Social History:				Comments:
Tobacco Use	Yes	No	Former	
Alcohol Use				
Illicit Drug Use				

Sunflower Medical Group Health History Form

Name:_____ Date of Birth:_____ Date:_____

HEALTHCARE PROVIDERS: Please list former/current specialty providers:

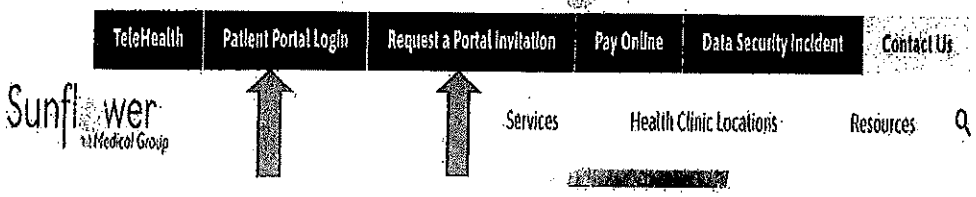
Former Primary Care Provider or Pediatrician: _____ Allergist/ENT:_____ Cardiologist:_____ Dentist:_____ Dermatology:_____ Endocrinology:_____ Gastroenterology:_____ Gynecology:_____	Cancer doctor:_____ Eye doctor:_____ Orthopedic Surgeon:_____ Pain Management:_____ Podiatrist:_____ Psychiatrist:_____ Pulmonologist:_____ Urology:_____ Other:_____

Family History:

	YES	NO	Relationship
Colon Cancer			
Breast Cancer			
Heart Disease			
Diabetes			
High Blood Pressure			
High Cholesterol			
Arthritis			
Other:			

Please list all surgeries and procedures: **Date:**

FollowMyHealth®



Click the button to "Request a Portal Invitation"

Instructions to Request an Invitation to the Follow my Health Patient Portal for You or Your Family Members:

- Go to our website at **www.sunflowermed.com**
- Click the button at the top of the page that says request a portal invitation. (See above)
- Fill out the information requested. If requesting for a child or multiple children, please type the parent information at the top of the form in the name section and the parent section (even if you are not a patient here). Then put the children's full legal name and DOB in the box at the bottom of the form.
- You will then receive an email invitation within the next 24-48 hours with instructions to set up your portal account.
- Please check your email (including spam folder) and activate your portal account using the link in the email invitation. Any questions, please contact us at 913-299-3700 x549.
- After you have activated your new patient portal account, you can log in using the "Patient Portal Login" button on our website or by downloading the follow my health app. So make sure you bookmark our website to your favorites!
- See backside for FAQ!

Your Follow my Health Patient Portal account allows you to send direct messages to your doctor, request appointments online, pay your bills online, see your immunizations and medications online, etc.! You will love the 24-hour convenience!